



Commonwealth of Massachusetts  
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747  
(617) 727-2310 www.mass.gov/gic

Insurance Enrollment and Change Form  
(FORM -1)

01 <input type="checkbox"/>		Insured's GIC-ID (usually Soc. Sec. #)		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth / /		Dept. ID # or Agency/Division # /	
Name - Last		First		MI					
Address		<input type="checkbox"/> This is a new address		City		State		Zip Code	
Date Entered Service / /		Bargaining Unit/Union Name		HR/CMS or UMASS Employee ID #:		Home Phone ( )		Work Phone ( )	
02 <input type="checkbox"/>		LIFE, HEALTH AND LTD COVERAGE						Effective Date: / 01 /	
New Enrollment <input type="checkbox"/>		Change <input type="checkbox"/>						Cancel Coverage	
<input type="checkbox"/> Basic Life Only		Annual Salary: \$				<input type="checkbox"/> Long Term Disability (LTD)			
<input type="checkbox"/> Long Term Disability (LTD)		Salary Effective Date: / /				<input type="checkbox"/> Health Insurance			
<input type="checkbox"/> Basic Life and Health (Select one of the Health Plans below)						<input type="checkbox"/> Optional Life Insurance			
Health Plan		<input type="checkbox"/> Fallon Direct (HMO)		<input type="checkbox"/> Fallon Select (HMO)		<input type="checkbox"/> Harvard Pilgrim Independence (PPO)		<input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	
		<input type="checkbox"/> Health New England (HMO)		<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO)		<input type="checkbox"/> Tufts Health Plan Navigator (PPO)		<input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	
				<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> UniCare/Community Choice (PPO-type)		<input type="checkbox"/> UniCare/PLUS (PPO-type)	
								<input type="checkbox"/> Individual <input type="checkbox"/> Family	
Optional Life Please Check One:		<input type="checkbox"/> Automatic Increase				Please Check One:			
Indicate Multiple Factor (1-8):		Indicate Multiple Factor (1-4):				<input type="checkbox"/> Smoker			
Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form.		Non Automatic Increase – Family Status Change				<input type="checkbox"/> Non-Smoker			
<input type="checkbox"/> Non Automatic Increase		Amount \$:				Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates			
No more than \$1000 less than annual salary rounded down to the nearest \$1,000		Marriage, divorce, birth/adoption, death of spouse. The GIC must receive documentation of family status change within 31 days of the event.							
03 <input type="checkbox"/> Name Change		Previous Name				New Name			
		LEAVE OF ABSENCE				FOR GIC USE ONLY:		Effective Date: / 01 /	
04 <input type="checkbox"/> Leave Is: <input type="checkbox"/> With Pay <input type="checkbox"/> Without Pay								Leave Pay Status: <input type="checkbox"/> Part <input type="checkbox"/> Full	
Leave Type (You MUST Check one of the following):									
<input type="checkbox"/> Educational		<input type="checkbox"/> Maternity		<input type="checkbox"/> Military Caregiver (26 weeks)		<input type="checkbox"/> FMLA (12 weeks)		<input type="checkbox"/> Personal Reason	
<input type="checkbox"/> Personal Illness		<input type="checkbox"/> Sabbatical		<input type="checkbox"/> FMLA Military Exigency (12 weeks)		<input type="checkbox"/> Family (for dep < age 3)		<input type="checkbox"/> Other	
<input type="checkbox"/> Industrial accident		<input type="checkbox"/> Suspension		<input type="checkbox"/> Military					
* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.									
Duration of Leave: Start Date / / End Date / / Last Day on Payroll / /									
05 <input type="checkbox"/> Return to Payroll Deduction: First Day Back on Payroll / /				FOR GIC USE ONLY:		Effective Date: / 01 /			
		INSURED CHANGES							
06 <input type="checkbox"/> Retirement		Date Retired / /		<input type="checkbox"/> ORP (Higher Ed Only)		Fund Name:			
07 <input type="checkbox"/> Transfer to another Agency		Name of Agency Transferred to				Effective Date / /			
08 <input type="checkbox"/> Transfer from another Agency		Previous Agency				Effective Date / /			
09 <input type="checkbox"/> Termination Coverage (if elected)		Termination Reason				Termination Date / /			
		<input type="checkbox"/> 39 -Week Layoff Coverage		<input type="checkbox"/> Deferred Retiree		<input type="checkbox"/> COBRA (must complete COBRA application)		<input type="checkbox"/> Conversion (contact carrier for application)	
SIGNATURE REQUIRED		Deduction Authorization: I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.							
		Long Term Disability Insurance (LTD): I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability.							
		Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.							
		Optional Life Insurance: I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change.							
		At Retirement: I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.							
		Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.							
		Termination: I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.							
		* If you are applying for Health Insurance, be sure to file a Form IDF to list family members.							
x		Signature of Applicant		Date		x		Signature of Authorized Official	
								Date	
FOR GIC USE ONLY:		Entered		Verified		Political Subdivision			